How to reach us

You can call, write or visit the Blue Cross Blue Shield of Michigan State of Michigan Customer Service Center when you have benefit and claims handling questions.

To help us serve you better, here are some important tips to remember:

- Have your ID card handy so you can provide your contract and group numbers. If you're writing, include this information in your letter.
- To ask if a particular service is covered, please have your physician provide you with the five-digit procedure code. If your planned procedure does not have a code, please obtain from your provider a complete description of the service. Please also include the diagnosis.
- To inquire about a claim, please provide the following:
  - Patient's name
  - Provider's name (such as the doctor, hospital or supplier)
  - Date the patient was treated
  - Type of service (for example, an office visit)
  - Charge for the service
- When writing to us, please send copies of your bills, other relevant documents and any correspondence you have received from us. Make sure you keep your originals.
- Include your daytime telephone number on all of your letters.

Calling

Our customer service hours are Monday through Friday from 8:30 a.m. to 4:45 p.m. We are closed on holidays.

In and outside Michigan **1-800-843-4876**

Hearing and speech impaired customers

Area codes 248, 313, 586, 734 and 810 ..... **(313) 225-6903**

Area codes 231, 616 and 989 ..... **(616) 977-8494 or 1-877-977-8494**

Area code 517 ..... **1-800-231-6921**

Special servicing numbers

Anti-fraud hotline **1-800-482-3787**

Blue HealthLine[SM] **1-800-811-1764**

Hearing-impaired customers ..... **TTY# 1-800-240-3050**

BlueSafe[SM] hotline ..... **1-877-BLUESAFE (258-3723)**

BlueCard® ..... **1-800-810 BLUE (2583)**

Human Organ Transplant Program **1-800-242-3504**

Writing

Please send all correspondence to:

State of Michigan Customer Service Center
Blue Cross Blue Shield of Michigan
P.O. Box 80380 - WRAP
Lansing, MI 48908-0380

Visiting

Our Customer Service Center is open Monday through Friday from 8:30 a.m. to 5 p.m. We are closed on holidays.

BCBSM State of Michigan Customer Service Center
1405 S. Creyts Road
Lansing, MI

Surfing the net

Blue Cross Blue Shield of Michigan Home Page ..... **www.bcbsm.com**

Anti-fraud ..... **www.bcbsm.com/antifraud**

Your ID card

Your BCBSM ID card is your key to receiving quality health care. Your card will look similar to the one below.

The numbers on your personal ID card will be different from the ones illustrated above.

The suitcase tells providers about your travel benefits.

Line 1: **CONTRACT NO.** This is your identification number, which is the subscriber's Social Security number. The subscriber is the person who signed and submitted the application for State Health Plan *PPO* coverage.

The alpha prefix preceding the contract number identifies the type of coverage you have (PPO).

PLAN CODE identifies you as a Blue Cross Blue Shield of Michigan member.

Line 2: **ENROLLEE NAME** is the same as the subscriber. All communications are addressed to this name.

Line 3: **GROUP NO.** tells us you are a BCBSM group subscriber.

Your Blue Cross Blue Shield of Michigan ID card is issued once you enroll for coverage. It lets you obtain services covered under the State Health Plan *PPO*. Only the subscriber's name (the subscriber is the person who signed and submitted the application for State Health Plan *PPO* coverage) appears on the ID card. However, the cards are for use by all covered members.

Here are some tips about your ID card:

- Carry your card with you at all times to help avoid delays when you need medical attention.
- If you or anyone in your family needs a card, please call the State of Michigan Customer Service Center at **1-800-843-4876** for assistance.
- Call the State of Michigan Customer Service Center at **1-800-843-4876** if your card is lost or stolen. Our customer service representatives are available 8:30 a.m. to 4:45 p.m. Monday through Friday, excluding holidays. You can still receive service by giving the provider your contract number to verify your coverage.

Only you and your eligible dependents may use the cards issued for your contract. Lending your card to anyone not eligible to use it is illegal and subject to possible fraud investigation and termination of coverage.

Explanation of benefits

You'll receive an *Explanation of Benefit Payments* form each time we process a claim under your contract number. **The EOBP is not a bill**. It's a statement that helps you understand how your benefits were paid. It tells you:

- The family member who received services
- Who provided the service, the payments made and any amount saved by using a participating provider under *Summary of Balances*
- *Helpful Information* about BCBSM programs
- Service dates, charges, payments and any balance you may owe under *Detail on Services*

Please check your EOBPs carefully. If you see an error, please contact your provider first. If they cannot correct the error, call the State of Michigan Customer Service Center at **1-800-843-4876**. Our customer service representatives are available 8:30 a.m. to 4:45 p.m. Monday through Friday, excluding holidays.

If you think your provider is intentionally billing us for services you did not receive or that someone is using your BCBSM ID card illegally, contact our anti-fraud hotline at **1-800-482-3787**.

Your call will be kept strictly confidential. By working together, we can help keep health care costs down.

We've included a sample *Explanation of Benefit Payments* form on the following page.

Eligibility guidelines

When are you eligible?

You're eligible as a retiree for State Health Plan coverage on the day your pension begins. This is known as your "eligibility date."

You can continue your coverage without interruption if:

- You retired under the Defined Contribution Plan
- You receive an immediate pension benefit under one of the following:
  - State Employees' Retirement Act
  - State Police Retirement Act

You can also enroll in the State Health Plan if you were previously enrolled in a State-sponsored Health Maintenance Organization and you receive an immediate pension benefit.

What makes a dependent eligible?

Eligible dependents include your spouse and any of your unmarried children until the end of the month in which they turn 19. In addition to being unmarried, children must meet the following conditions to be considered eligible. They must be:

- Your children by birth or legal adoption who are in your custody and dependent on you for support. You'll need to provide proof of dependency.
- Your children by birth or legal adoption who do not reside with you, but are your legal responsibility for the provision of medical care (for

example, children of divorced parents).

In the case of legal adoption, a child is eligible for coverage as of the date of placement. Placement occurs when you become legally obligated for the total or partial support of the child in anticipation of adoption. A sworn statement with the date of placement or a court order verifying placement is required.

Your dependent's coverage will automatically terminate on the last day of the last month for which you made any required dependent premium contribution *and*:

- When your dependent no longer meets the definition of an eligible dependent (You must immediately notify the Office Retirement Services if you divorce. Ex-spouses are not eligible for coverage.)
- When the entire group or the group dependent contract is discontinued
- When your coverage terminates

Under certain circumstances, you can continue coverage for dependent children past the age of 19. For more information please see the section on *Continuing coverage for dependents*.

Dependent exclusions

You cannot claim a dependent on your coverage if he or she is:

- In the armed forces

  No person will be considered a dependent while in the armed forces of any country.
- Already covered on another State of Michigan Health Plan

  No person can be covered by more than one State of Michigan Health Plan.

If you and your spouse are both covered by State Health Plans (retiree or active, including State-sponsored HMO options), you may:

- Maintain separate coverage through your individual plans
- Enroll in one plan, with one of you as a dependent

If you choose to maintain separate coverage, your child or children can only be listed on one plan, not both. This applies even if you are divorced.

If an actively employed spouse separates from State service, takes a leave of absence or becomes laid off, he or she may enroll in the retiree's State Health Plan if he or she:

- Meets dependent eligibility requirements
- Notifies his or her human resources office and the Office to Retirement Services of the intent to transfer enrollment before departing from State service

You also cannot claim a new spouse as a dependent if you are receiving benefits as the surviving spouse of a State employee or retiree.

Applying for coverage

To apply for State Health Plan coverage or to ensure uninterrupted coverage, you'll need to submit a retiree *Group Insurance Application* to the Office of Retirement Services. To request the form, call the ORS using one of the following telephone numbers:

Lansing area.....(517) 322-5103

Toll free 1-800-381-5111

Mail the completed form to:

Office of Retirement Services
P.O. Box 30171
Lansing, MI 48909-7671

If you're a defined contribution retiree, you'll also need to complete a *Defined Contribution Plan Notice of Retiree Group Insurance Eligibility* form. This form is also obtained from the ORS.

You must decide within 31 days *after* your eligibility date whether you'll enroll in the plan. If you choose not to enroll within this timeframe, your coverage, and that of your eligible dependents, will not be effective until six months after the first day of the month in which the Office of Retirement Services receives your completed application.

However, the six-month waiting period can be waived, and coverage can begin within 31 days after your completed application is received, if:

- You get married

  Within 30 days of your marriage, send a letter of notification to the Office of Retirement Services that includes your new spouse's name, date of birth, Social Security number and Medicare information. Include a copy of your marriage license.

- You need to enroll in the plan because you or your dependents are losing coverage from another group plan

  To receive consideration, please submit your application with a letter from the employer that states:

  — Who was covered under the plan

  — Why coverage is ending

  — The date the coverage ends

The address for ORS can be found on this page.

Changing coverage

You can make mid-year enrollment changes to your coverage based on a family status change. These changes occur if you or your dependents lose or need coverage because:

- You get married or divorced
- An eligible child is born, adopted or moves into your home
- Your spouse begins or ends employment
- Your spouse changes from part-time to full-time (or vice versa) or takes an unpaid leave of absence resulting in a significant change in your coverage
- There is a significant change in your or your spouse's coverage through your spouse's non-State of Michigan employer plan
- Your dependent 19- to 25-year-old child has returned to school

To make mid-year enrollment changes, notify the Office of Retirement Services, in writing within 31 days of the date of the event. The changes in coverage will be effective retrospectively to the qualifying event *after* the ORS receives the written request for change and documentation of the qualifying event.

The address for ORS can be found on the previous page.

Continuing coverage for dependents

State Health Plan coverage will automatically continue for a dependent who is to receive an immediate monthly pension benefit from the State of Michigan upon your death.

Dependents of defined contribution retirees will be entitled to continue coverage through the retiree group.

If your dependent is not going to receive a monthly pension benefit following your death, his or her coverage will end 30 days following your death.

If your dependent's enrollment in the State Health Plan is canceled, he or she may be eligible for continuing coverage. We've detailed the options on the following pages.

Continuing coverage for dependent children

If your coverage is **still active** but your dependent child no longer meets the eligibility criteria outlined in the section *What makes a dependent eligible?*, your dependent child can remain on your coverage if he or she is:

- Unmarried and between the ages of 19 and 25
- Dependent on you for financial support
- A student who regularly attends school

This coverage will continue until the end of the month in which the child turns 25 if he or she remains eligible. Coverage for these dependents will be the same as yours.

Continuing coverage for incapacitated children

Incapacitated children are those who are unable to earn a living because of a mental or physical impairment and must depend on their parents for support and maintenance.

If your enrolled dependent is an incapacitated child, your coverage for this child will continue beyond age 19 as long as he or she became incapacitated before age 19, continues to be incapacitated and your coverage does not terminate for any other reason.

To ensure uninterrupted coverage for your incapacitated child, you must

apply for continuation coverage before the end of the month in which the child turns 19. To apply for continuation coverage, contact the Office of Retirement Services for a BCBSM application card.

Telephone numbers and the address for the ORS are:

Lansing area.....(517) 322-5103

Toll free 1-800-381-5111

Office of Retirement Services
P.O. Box 30171
Lansing, MI 48909-7671

Continuing coverage under COBRA

Your dependents may also be eligible for continuing coverage under the federal law known as COBRA. COBRA requires the State of Michigan to offer eligible dependents of retirees continued group insurance coverage. COBRA applies to:

- Surviving dependents who will lose the retiree group coverage in the case of your death
- Spouses who lose coverage because of divorce or legal separation
- Children who no longer meet dependent eligibility requirements under the State Health Plan.

If your eligible dependents choose COBRA, they may continue State of Michigan coverage for up to 36 months by paying the full monthly premium (including the share that was paid by the State) directly to the State of Michigan.

To apply for continuation of coverage, your eligible dependents must

submit an *Application for Continuation of Insurance Benefits* (form MDCS-1499) to the employee Benefits Division no later than 60 days from the date of your death, or the date coverage ended, whichever is later and whichever applies.

The address for the Employee Benefits division is:

Office of the State Employer
Employee Benefits Division
P.O. Box 30026
Lansing, MI 48909

This continuation opportunity will end if an application is not submitted on a timely basis or the full COBRA premium is not paid.

Continuing coverage under BCBSM group conversion

BCBSM's individual coverage, called group conversion, is available to your eligible dependents either:

- As an alternative to COBRA when they first become eligible for COBRA
- At the end of the COBRA eligibility period if they made all required payments during that period

Benefits for your eligible dependents will change under group conversion coverage, but there will be no interruption of coverage provided they pay the initial and subsequent premiums. Your dependents must be Michigan residents for at least six months out of each year to be eligible for this type of coverage.

To ensure continuous coverage, your dependents must submit a written request for group conversion coverage to Blue Cross within 30 days from the date they are no longer eligible for State Health Plan coverage **or** within six months before the COBRA coverage ends.

For additional information on how to apply for BCBSM conversion coverage please call our Direct Billed Servicing department at **1-800-848-5101**. Customer service representatives are available Monday through Friday, 8:30 a.m. to 5 p.m.

Discontinuing coverage

You can voluntarily cancel your State Health Plan coverage or your dependent's coverage at any time by writing to the Office of Retirement Services at:

Office of Retirement Services
P.O. Box 30171
Lansing, MI 48909-7671

Include your signature and Social Security number.

The cancellation effective date will be the last day of the month in which a premium (or dependent contribution) is paid.

In the event of divorce, the cancellation date is the date of the divorce.

Certificate of creditable coverage

The Health Insurance Portability and Accountability Act of 1996 requires all health plans to provide a certificate of creditable coverage to any individual who loses health coverage. The certificate rules help ensure that coverage is portable, which means that once a person has coverage, he or she can use it to reduce or eliminate any pre-existing condition exclusion periods that might otherwise apply when changing coverage. When your coverage through your employer ends, you will receive a certificate of coverage.

Choosing a network provider

To receive care with the lowest out-of-pocket costs, choose providers from the *BCBSM Community Blue/Blue Preferred PPO Network*. The network is made up of physicians, hospitals and other health care specialists who have signed agreements with Blue Cross to accept our approved amount as payment in full for covered services.

When you receive services from a PPO network provider, your out-of-pocket costs are limited to in-network deductibles and copayments. You don't have to choose just one provider, and you don't have to notify us when you change physicians.

To find PPO providers, call the State of Michigan Customer Service Center at **1-800-843-4876**, and ask for assistance in locating PPO providers in your area. Or visit **www.bcbsm.com**.
When you visit www.bcbsm.com:

1. Click on "Members & Groups"
2. Click on "Physician Search"
3. From the Site Search Menu sidebar click on the provider type you're looking for:
   - "Physician Search"
   - "Hospitals & Facilities"
   - "Community Blue PPO Urgent Care Locations"

When you're searching for a physician follow the steps on the Physician Search site.

Step 1 Choose a plan. Click "Community Blue/Blue Preferred PPO" on the drop-down menu.

Step 2 Select from the following options. To narrow your search, select

more than one:

Option A: Locate Specific Physician — Type the physician's name.

Option B: Get a List of Physicians — Choose a specialty from the drop-down menu or choose a hospital from the drop-down menu.

Option C: Locate a Physician Near You — Type the number of miles you are willing to travel and your address.

Option D: Locate a Physician by County or ZIP — Choose a county from the drop-down menu or type your ZIP code.

Click on "Search" — The physicians will appear in alphabetical order.

For additional information about a physician, select one of the following from the drop-down menu to the right of the individual physician list:

Physician Details
Driving Directions
Map to Physician

If you're searching for a hospital or facility:

1. Click on "Hospital & Facilities" from the Site Search menu sidebar.
2. Click on the region on the map or the name of the region you are interested in.
3. Click the facility type on the drop-down menu.
4. Click "Community Blue PPO" as the plan type on the drop-down menu.
5. Click the county on the drop-down menu.
6. Click on "Search" — The hospitals and facilities will appear in alphabetical order.

If you're searching for an urgent care location:

1. Click "Community Blue PPO Urgent Care Locations" on the Site Search

menu sidebar.

2. Select the region on the map or the name of the region you are interested in.
3. Select the county. The urgent care locations will appear in alphabetical order.

What happens if your PPO physician leaves the network

Your physician is your partner in managing your health care. However, physicians retire, move or otherwise cease to be affiliated with our PPO network. Should this happen, your physician will notify you that he or she is no longer in the PPO network. If you have difficulty choosing another physician, please contact the State of Michigan Customer Service Center at **1-800-843-4876** for assistance. If you wish to continue care with your current physician, a customer service representative will explain the financial costs to you when services are performed by a physician who is no longer in the PPO network.

Non-network providers

When you receive care from a provider who is not part of the PPO network, without a referral from a PPO provider, your care is considered out-of-network. For most out-of-network services, you have a 10 percent copayment and a higher deductible. Some services, such as your preventive care services, are not covered out-of-network.

Nonparticipating providers

In addition to the out-of-network deductible and copayments, you may also be responsible for any charge above BCBSM's approved amount. That's because providers who don't participate with the Blues may choose *not* to accept BCBSM's approved amount as payment in full for covered services.

You may also be required to file your own claim.

When you use nonparticipating providers, we'll send you our approved amount, less the out-of-network deductible and copayments. You're responsible for paying the provider. Some services, such as your preventive care services, are not covered when you use nonparticipating providers.

They're not PPO, but they're still Blue

If you choose to receive services from a non-network provider, you can still limit your out-of-pocket costs if the provider participates in the Blues Traditional plan. When you use Blues participating providers:

- You won't have to submit a claim. The provider will bill us directly for your services.
- You won't be billed for any differences between our approved amount and their charges.

Remember, some services, such as your preventive care services, are not covered out-of-network.

Non-PPO hospitals and facilities

If you choose to go to a non-PPO hospital or facility when you have adequate access to a network hospital, the State Health Plan *PPO* will pay 90 percent after your deductible. You will be responsible for the difference.

Nonparticipating hospitals and facilities

If you choose to go to a nonparticipating hospital when you have adequate access to a network hospital, the State Health Plan *PPO* will not cover the charges.

BlueCard PPO

When you need medical care outside of Michigan, you can receive in-network benefits by using the BlueCard® PPO program. BlueCard PPO providers bill their local Blues Plan for any covered services you receive and will accept the approved amount or negotiated price as payment in full. You're only responsible for applicable in-network deductibles and copayments and for services not covered by the State Health Plan *PPO*.

If you need emergency medical care, please seek care immediately from the nearest hospital or physician. Otherwise, just follow these steps:

1. Call **1-800-810-BLUE** (2583) any day of the week. You'll be given the name of the nearest PPO physician or hospital.
2. Show your Blue Cross Blue Shield ID card to the provider. Remind him or her to include the XYP alphabetical prefix on all of your claims.
3. Pay the applicable deductibles and copayments required by the State Health Plan *PPO*.

If you're in one of the few areas without Blues PPO or participating providers, you won't be expected to pay any out-of-network copayments or deductibles. However, you may need to submit itemized receipts directly to us if you receive services from a non-network provider.

BlueCard does not include prescription drugs, dental, vision and hearing services.

Care out of the country

The State Health Plan PPO will only pay for services for emergency and unexpected illness for residents of the United States traveling in foreign countries. In addition, coverage applies only if:

- The hospital is accredited
- The physician is licensed

Most hospitals and doctors in foreign countries will ask you to pay the bill. Try to get itemized receipts, preferably written in English. When you submit your claim, tell us if the charges are in U.S. or foreign currency. Be sure to indicate whether payment should go to you or the provider. We'll pay the approved amount for covered services at the rate of exchange in effect on the date you received your services, minus any deductibles or copayments that may apply.

CALL-OUT BOX 1
To receive care with the lowest out-of-pocket costs, choose providers from the BCBSM *Community Blue/Blue Preferred PPO Network*. The network is made up of physicians, hospitals and other health care specialists who have signed agreements with Blue Cross to accept our approved amount as payment in full for covered services.

CALL-OUT BOX 2

Exceptions to the rule

Out-of-network deductibles and copayments will be waived if you don't have adequate access to a PPO provider. Adequate access is defined by how far you live from PPO providers and hospitals.

The State Health Plan *PPO* access standards are as follows:

- Two family care physicians within 15 miles of your home
- Two specialty care physicians within 20 miles of your home
- One hospital within 25 miles of your home

CALL-OUT BOX 3

If you choose to go to a non-PPO hospital or facility when you have adequate access to a network hospital, the State Health Plan *PPO* will pay 90 percent after your deductible. You will be responsible for the difference.

Your State Health Plan PPO benefits

Under the State Health Plan *PPO*, covered services and supplies are called benefits. The payment allowed for benefits is called the approved amount. Blue Cross Blue Shield of Michigan determines the approved amount. Applicable deductibles and copayments are deducted from the approved amount.

Payment of your State Health Plan *PPO* benefits, including deductibles, are based on a calendar year beginning January 1 and ending December 31.

Dollar maximums

Covered services are limited to a lifetime dollar maximum of $5 million per member. This does not include human organ transplants, which have a separate dollar maximum. The dollar maximum for human organ transplants is $1 million per transplant.

Out-of-pocket costs

For most covered services, you are required to pay a portion of the approved amount through deductibles and copayments.

Deductibles

Deductibles are out-of-pocket costs you're required to pay before benefits are payable for covered services. There are different amounts for individuals and families. When one individual has met the deductible, benefits are payable for covered services **for that individual**. Services for the remaining family members will be paid when the full family deductible has been met.

Deductible amounts are determined by whether you receive services in- or out-of-network. Deductibles are applied to one or the other, but not both. Your in- and out-of-network deductibles are noted below.

Out-of-pocket	In-network	Out-of-network
Individual	$200	$500
Family	$400	$1,000

Deductibles are required each calendar year.

Any amount you pay toward your in-network deductible during the fourth quarter (October through December) will carry over and be applied to your in-network deductible the following year.

Copayments

After you've met your deductible, you're responsible for copayments with one exception. There are no required deductibles for in-network office visits. There is a deductible for office visits out-of-network. Only the $10 copayment applies to office visits. As with deductibles, copayment amounts are determined by whether you receive services in- or out-of-network. Copayments are applied to one or the other, but not both.

Copayments	In-network*	Out-of-network*
Fixed-dollar	$10 for office visits, office consultations, urgent care, osteopathic manipulations and medical hearing exams	Not applicable There is no fixed dollar copayment for out-of-network services.
Percentage	10% for durable medical equipment, prosthetic and orthotic appliances, private	10% for most services including office visits

duty nursing, chiropractic manipulation and acupuncture

*Services without a network are covered at the in-network level.

Annual copayment maximums

You're only required to pay a certain amount in copayments each year:

Out-of-pocket maximum	In-network	Out-of-network
Individual	$1,000	$2,000
Family	$2,000	$4,000

However, certain copayments and other charges *cannot* be used to meet your copayment maximum. They are as follows:

- Fixed-dollar copayments
- Private duty nursing copayments
- Deductibles
- Charges for noncovered services
- Charges in excess of our approved amount
- Deductibles or copayments required under other Blue Cross Blue Shield of Michigan coverage

Hospital coverage

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
Annual deductible	10% after annual deductible	100%

We've provided detailed information on your hospital coverage in the following pages. However, first we've provided important information on medical necessity and pain management.

Medical necessity

Unless otherwise specified, a service must be medically necessary in order to be covered by the State Health Plan *PPO*. Below, we've explained what medical necessity means for hospital services.

Medical necessity for hospital services

Medical necessity for the payment of hospital services requires that all of the following conditions be met:

- The covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease.
- The service, treatment or supply is appropriate for the symptoms and is consistent with the diagnosis.
- "Appropriate" means the type, level and length of care, treatment or supply and setting that are needed to provide safe and adequate care and treatment.
- For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate

care cannot be received as an outpatient or in a less intensified medical setting.

- The services are not mainly for the convenience of the member or health care provider.
- The treatment is not generally regarded as experimental or investigational by Blue Cross Blue Shield of Michigan.
- The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment programs.

In some cases, you may be required to pay for covered services *even when they're medically necessary*. These limited situations are:

- When you don't inform the hospital that you're a BCBSM member either at the time of admission or within 30 days after you have been discharged
- When you fail to provide the hospital with information that identifies your coverage

Pain management

Blue Cross Blue Shield of Michigan considers pain management an integral part of a complete disease treatment plan. We provide coverage for the comprehensive evaluation and treatment of diseases, including the management of symptoms such as intractable pain that may be associated with these diseases. Your health care benefits provide for such coverage and are subject to contract limitations.

Inpatient hospital benefits

Your coverage includes the following inpatient hospital services at a PPO network hospital:

- **Room and board** – Includes:
  - The cost of a semi-private room

— The use of special units such as intensive, burn or cardiac care

— Meals and special diets

— General nursing care

The cost of a private room is not covered. If you request a private room, your coverage will pay for the cost of a semi-private room and you'll be required to pay the difference.

- **General medical care days** — You have an unlimited number of inpatient days available for the diagnosis and treatment of general medical conditions. This includes admissions for:

  -—Maternity and nursery care – Includes delivery room costs, birthing center services, and routine nursery care for a newborn during an eligible mother's hospital stay.

  After the hospital stay, the newborn is covered as a dependent child, but only if you add the child to your coverage within 31 days of birth.

  Under federal law, BCBSM generally cannot restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. However, the attending physician may, after consulting with the mother, discharge the mother or the newborn earlier. BCBSM also cannot require a provider to obtain authorization for prescribing a length of stay not in excess of the 48-/96-hour minimum.

  — **Cosmetic surgery** – Includes correction of birth defects, conditions resulting from accidental injuries, deformities resulting from certain surgeries, such as breast reconstruction following mastectomies.

  — **Dental surgery** – Includes removal of impacted teeth or multiple extractions **only** when a concurrent hazardous medical condition, diagnosed by a physician, exists. The inpatient stay must be considered medically necessary to safeguard the life of the patient during the dental surgery.

- **Diagnostic and radiology services** — The following diagnostic and radiology services are covered during a hospital admission:

- **CAT and MRI scans** — Includes scans of the head and body when required for eligible diagnoses and when performed in a facility approved by BCBSM.
- **Diagnostic tests** — Includes EKGs, EMGs, EEGs, thyroid function tests and nerve conduction studies required in the diagnosis of an illness or injury.
- **Therapeutic radiology** — Includes radiological treatment by X-ray, isotopes or cobalt for a malignancy.
- **Diagnostic radiology** — Includes ultrasounds and X-rays required for the diagnosis of an illness or injury.

- **Hospital services and supplies** — The following services and supplies are covered during a hospital admission when needed:
  - **Anesthesia** — Includes administration, cost of equipment, supplies and the services of a hospital anesthesiologist when billed as a hospital service.
  - **Blood services** — Includes blood derivatives, blood plasma and supplies used for administering the services as well as the cost of drawing and storing self-donated blood intended for scheduled surgery.
  - **Laboratory and pathology tests** — Includes laboratory tests and procedures required to diagnose a condition or injury when billed as a hospital service.
  - **Drugs** — Includes biologicals and medicines prescribed and given during a hospital admission.
  - **Durable medical equipment** — Includes items such as oxygen tents, wheelchairs and other hospital equipment used during the hospital stay.
  - **Medical and surgical supplies** — Includes gauze, cotton and solutions used during the hospital admission.
  - **Prosthetic and orthotic appliances** — Includes items surgically implanted in the body, such as heart valves.

— **Special treatment rooms** — Includes operating, delivery and recovery rooms.

Outpatient hospital benefits

The following services are covered when performed in the outpatient department of a PPO network hospital or, where noted, in a freestanding facility approved by BCBSM.

- **Pre-admission testing** — Testing **must** be performed within seven days before a scheduled hospital admission or surgery. These tests must be medically appropriate, valid at the time of admission and must not be duplicated during the hospital stay.
- **Emergency medical care** — The initial exam and treatment of accidental injuries or conditions in an emergency room are covered when determined by BCBSM to be medical emergencies. This includes both professional and facility services. Treatment must occur within 48 hours of the injury or 72 hours of the medical emergency.

  Routine care for minor medical problems such as headaches, colds, slight fevers and back pain is not considered emergency care. Also, follow-up care is not considered emergency care.
- **Professional ambulance services** — Ambulance services are covered if the destination is the nearest medical facility capable of treating the patient's condition.

  The service must be:

  — Medically necessary because transport by any other means would endanger the patient's health

  — Prescribed by a physician (when used for transferring a patient)

  — Provided in a vehicle qualified as an ambulance and part of a licensed ambulance operation

  Air or water ambulance is also covered if it's medically necessary,

ordered by the attending physician and the patient's emergent condition requires air or water transport rather than ground ambulance. The transport must be to the closest facility that can treat the patient. Air or water ambulance providers must be licensed to provide air or water ambulance services and **not** as a commercial air carrier.

Your coverage does **not** pay for transportation for the convenience of the patient, the patient's family or the preference of the physician.

- **Chemotherapy** — Treatment is payable in a hospital, in the outpatient department of a hospital, in a physician's office or in the patient's home.

  Benefits include the administration and cost of drugs when they are:

  — Ordered by a physician for the treatment of a specific type of disease

  — Approved by the Food and Drug Administration for use in chemotherapy

  — Provided as part of a chemotherapy program

  Benefits also include three follow-up visits within 30 days of your last chemotherapy treatment to monitor the effects of chemotherapy.

- **Sterilization** — This benefit applies to both males and females. A medical reason is not required.

- **Termination of pregnancy**

- **Hemodialysis** — Hemodialysis services are covered to treat acute kidney failure and end stage renal disease. Patients can receive treatment in the inpatient or outpatient department of a hospital, in a licensed facility or at home. (For more information on home hemodialysis services see the Alternative to Hospital Care section of this book.)

  Coverage for ESRD dialysis services is coordinated with Medicare. It's important that individuals with ESRD apply for Medicare coverage regardless of age. The State Health Plan *PPO* is the primary payer for up to 33 months, which includes a three-month waiting period, if the member is under 65 and eligible for Medicare solely because of ESRD.

- **Physical, occupational and speech therapy** — Your physical,

occupational and speech therapy services are payable when provided in the outpatient department of a participating hospital.

Services are limited to a combined maximum of 60 visits per calendar year.

Physical therapy is the use of specific activities or methods to treat disability when there is a loss of neuromusculoskeletal function due to an illness, injury or following surgery. It must require the assistance and supervision of the appropriate licensed therapist and be:

— Prescribed by the patient's attending physician

— Designed to improve or restore the patient's functioning level after a loss in musculoskeletal functioning due to an illness or injury

— Provided for a condition that is capable of significant improvement in a reasonable and generally predictable period of time

Examples of covered services are:

— Therapy prescribed to restore musculoskeletal functioning

— Therapy used in conjunction with a treatment program to accelerate the healing of an acute injury or illness involving the muscles or joints

Physical therapy is also covered when provided in:

— Outpatient participating physical therapy facilities

— Physicians' offices

— Independent licensed physical therapists' offices

— In the home if part of a home health care treatment plan

Occupational therapy is a rehabilitative service that uses specific activities or methods to:

— Develop, improve or restore the performance of necessary neuromusculoskeletal functions affected by an illness, injury or following surgery

— Help the patient learn to apply the newly restored or improved

function to meet the demands of daily living

Speech and language pathology services are rehabilitative services that use a specific activity or method to treat speech, language, swallowing or voice impairment due to an illness, injury or following surgery.

Your benefit covers therapy for:

— Nondevelopmental speech disorders, which are characterized by a communicative loss caused by trauma or organic conditions such as aphasia following a stroke or dysphonia resulting from vocal cord surgery

— Severe congenital and developmental speech disorders, which are characterized by severe communicative deficits as a result of congenital (present at or existing from birth) and developmental conditions, for children age 6 and under

Your coverage for physical, occupational and speech therapy does **not** pay for:

— Long-standing, chronic conditions such as arthritis

— Massage therapy

— Health club membership or spa membership

— Developmental conditions or learning disabilities for members over the age of 6

— Congenital or inherited speech abnormalities for members over the age of 6

— Inpatient hospital admissions principally for speech or language therapy

Physician and other professional services

We've provided detailed information on your physician and other professional benefits in the following pages. However, first we've provided important information on medical necessity of physician benefits.

Medical necessity

Unless otherwise specified, a service must be medically necessary in order to be covered by the State Health Plan *PPO*. Below, we've explained what medical necessity means for physician services.

Medical necessity for physician services

Medical necessity for physician services is determined by physicians acting for their respective provider types or medical specialty and is based on criteria and guidelines developed by physicians and professional providers. It requires that:

- The covered service is generally accepted as necessary and appropriate for the patient's condition, considering the symptoms. The covered service is consistent with the diagnosis.
- The covered service is essential or relevant to the evaluation or treatment of the disease, injury, condition or illness. It is not mainly for the convenience of the members or physicians.
- The covered service is reasonably expected to improve the patient's condition or level of functioning. In the case of diagnostic testing, the results are used in the diagnosis and management of the patient's care.

The BCBSM determination of medical necessity for payment purposes is based on standards of practice established by physicians.

Preventive services

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
$0 up to the yearly dollar maximum	100%	100%

Your coverage pays for the preventive services listed below when they're received from network providers. The annual dollar maximum for preventive services in 2003 is $500 per member. This amount will increase to $750 January 1, 2004.

- **Health maintenance exam** — This includes a comprehensive history and physical exam. It also includes the following laboratory and radiology procedures when performed as a routine screening:
  - — Chemical profile
  - — Complete blood count
  - — Urinalysis
  - — Chest X-ray
  - — EKG

- **Annual gynecological exam** — Covered one per calendar year
- **Pap smears** — Covers laboratory services for one routine Pap smear per calendar year

  More frequent Pap smears are covered for the following conditions:
  - — Previous surgery for vaginal, cervical or uterine malignancy
  - — Presence of a suspected lesion in the vaginal, cervical or uterine areas

— Post-surgery

- **Well-baby and child care** — Number of visits as follows:
  — Six visits for children zero through 12 months
  — Six visits for children 12 months through 24 months
  — Two visits per birth year for children 24 months through 48 months
  — One visit each birth year for children 48 months through 15 years

- **Colorectal screenings** — Beginning at age 50, members should have **one** of these screenings:
  — A fecal occult blood test every year *and* a flexible sigmoidoscopy every five years or
  — A colonoscopy every 10 years or
  — A double contrast barium enema every five to 10 years (This benefit is not subject to the preventive services dollar maximum.)
- **Prostate Specific Antigen screening** — One per calendar year
- **Flu shots** — There is no age limit on flu shots.
- **Immunizations** — There is no age limit on immunizations.
- **Hepatitis C screenings** — There is no age limit on Hepatitis C screenings.

CALL-OUT Box
Your coverage pays for the preventive services listed when they're received from network providers. The annual dollar maximum for preventive services in 2003 is $500 per member. This amount will increase to $750 January 1, 2004.

Surgical services

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
Annual deductible	10% after annual deductible	Annual deductible plus the difference between the BCBSM approved amount and the provider's charge

Surgical benefits include the surgical fee and pre- and post-operative medical care given by the surgeon. Surgery is covered inpatient and outpatient, in the physician's office and in ambulatory surgical facilities.

Multiple surgeries (two or more surgical procedures performed by the same physician during one operative session) are subject to the following payment limitations:

- When surgeries are through **different** incisions, the State Health Plan *PPO* pays the approved amount for the more costly procedure and one half of the approved amount for the less costly procedure.
- When surgeries are through the **same** incision they are considered related and the State Health Plan *PPO* pays the approved amount only for the more difficult procedure.

Participating providers accept these approved amounts as payment in full. However, nonparticipating providers may bill you for the difference.

Cosmetic or reconstructive surgery is covered only for the correction of the following:

- Birth defects
- Conditions resulting from accidental injuries
- Deformities resulting from certain surgeries, such as breast

reconstruction following mastectomies

Breast reconstruction surgery is covered for:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

Dental surgery performed on an inpatient basis is covered only for the removal of impacted teeth or multiple extractions. The patient must be hospitalized for the surgery because a concurrent medical condition, diagnosed by a physician, exists. The inpatient admission for the dental surgery must be considered medically necessary to safeguard the life of the patient.

Benefits are limited to services performed by an MD or DO, including anesthesia services, and services billed by the facility.

Dental procedures performed by a DDS must be billed to the dental program.

Cataract surgery and first lens implants are covered.

Voluntary sterilization for both male and female patients is covered regardless of medical necessity.

Termination of pregnancy is also covered.

Additional surgical services covered:

- **Technical Surgical Assistance** — TSA is a covered benefit for certain major surgeries that require surgical assistance by another physician.

TSA is covered inpatient and outpatient, and in approved ambulatory surgery facilities.

- **Anesthesia** — Services for giving anesthesia are payable to a physician other than the operating or assisting physician, and to certified registered nurse anesthetists. We do not pay for local anesthetics.
- **Some medical surgeries performed by a DDS**

Inpatient medical care

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
Annual deductible	10% after annual deductible	Annual deductible plus the difference between the BCBSM approved amount and the provider's charge

When you receive inpatient or skilled nursing care, you're covered for an unlimited number of medical care visits by a physician for general medical conditions that are not related to surgery or maternity care.

Inpatient and outpatient consultations

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
Annual deductible	10% after annual deductible	Annual deductible plus the difference between the BCBSM approved amount and the provider's charge

Medical consultations are payable when your physician requires assistance in diagnosing or treating a medical condition because a special skill or knowledge of the consulting physician is required.

Emergency care

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
$0	$0	$0

Your coverage provides payment for the initial examination and treatment of accidental injuries and conditions determined by BCBSM to be medical emergencies. Treatment must occur within 48 hours of the injury or 72 hours of the medical emergency. (Please see the ***Glossary*** for definitions of these terms.)

Diagnostic and radiation services

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
Annual deductible	10% after annual deductible	Annual deductible plus the difference between the BCBSM approved amount and the provider's charge

Your benefits include physician services for diagnostic and radiation services to diagnose and treat disease, illness, pregnancy or injury through:

- Diagnostic radiology, which includes X-rays, ultrasound, radioactive isotopes, and MRI and CAT scans of the head and body when performed for an eligible diagnosis at a BCBSM approved facility
- Laboratory and pathology tests
- Diagnostic tests, which include EKGs, EMGs, EEGs, thyroid function tests, nerve conduction and pulmonary function studies
- Radiation therapy, which includes radiological treatment by X-ray, isotopes or cobalt for a malignancy
- Mammography screening, which covers one mammogram (breast X-ray) for a woman from the age of 35 to 40

At 40 and older, one mammogram per calendar year is covered. More frequent mammograms are covered if requested by your physician because of the suspected or actual presence of a disease or when required as a post-operative procedure.

Digital mammography is covered and paid at the same rate as standard film mammography.

Allergy testing

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
Annual deductible	10% after annual deductible	Annual deductible plus the difference between the BCBSM approved amount and the provider's charge

The State Health Plan *PPO* pays for allergy testing, survey testing and

therapeutic injections when performed by or under the supervision of a physician. Allergy extract and extract injections are also covered. Benefits are not payable for fungal or bacterial skin tests, such as those given for tuberculosis or diphtheria, self-administered or over-the-counter medications, psychological testing, evaluation or therapy for allergies, environmental studies, evaluation or control.

Acupuncture

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
10% after annual deductible	10% after annual deductible	Annual deductible plus the difference between the BCBSM approved amount and the provider's charge

Your acupuncture benefit covers up to a maximum of 20 treatments in a calendar year. These services are covered when performed by or under the supervision of a licensed physician (MD or DO).

Acupuncture is covered only for the treatment of the following conditions:

- Sciatica
- Neuritis
- Postherpetic neuralgia
- Tic douloureux
- Chronic headaches such as migraines
- Osteoarthritis
- Rheumatoid arthritis

- Myofascial complaints such as neck and lower back pain

Dental work

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
Annual deductible	10% after annual deductible	Annual deductible plus the difference between the BCBSM approved amount and the provider's charge

Certain dental work or oral surgery, limited to the following, is also covered:

- Treatment of jaw fractures, dislocations and wounds
- Treatment of cysts, tumors or other diseases of the tissues of the oral structures
- Other incision/excision procedures of the gums (periodontics) and tissues of the mouth when not done in conjunction with tooth repair or extraction
- Charges for dental services, office consultations and appliance therapy related to the above procedures

Treatment for Temporomandibular Joint Syndrome or Jaw-Joint Disorder

What you pay for covered services

In-network	Out-of-network	Nonparticipating
Annual deductible	10% after annual deductible	Annual deductible plus the difference between the BCBSM approved amount and the provider's charge

Benefits for TMJ or jaw-joint disorder are limited to:

- Surgery directly to the jaw joint
- X-rays (including MRIs)
- Trigger point injections
- Arthrocentesis (injection procedures)

Some symptom management services, such as office visits, reversible appliance therapy and physical medicine (diathermy, hot and cold applications) and medications are also covered.

Your TMJ benefit does not cover irreversible TMJ services with the exception of surgery directly related to the jaw joint as noted above.

Radial keratotomy

What you pay for covered services

In-network	Out-of-network	Nonparticipating
Annual deductible	10% after annual deductible	Annual deductible plus the difference between the BCBSM approved amount and the provider's charge

Radial keratotomy is covered only when all of the following criteria are met:

- The patient is at least 18 years old.
- The patient has myopia of -2.00 diopters (spherical equivalent or greater).
- The patient has had a stable refractive error (+ or - .50 diopter) for at least one year.
- The patient is unable to wear glasses or contact lenses satisfactorily due to occupational, recreational or psychological reasons.

Maternity care

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
Annual deductible	10% after annual deductible	Annual deductible plus the difference between the BCBSM approved amount and the provider's charge

You have coverage for obstetrical services including delivery and pre- and post-natal care visits. Inpatient examinations of the newborn are a benefit when performed by a physician other than the anesthesiologist or the delivering provider.

Maternity care benefits also are payable when provided by a certified nurse midwife. Delivery must be in a hospital or BCBSM-approved birthing center.

Physician office services

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
$10 copayment in physician's office, urgent care, office consultations, osteopathic manipulations and medical hearing exam Annual deductible for outpatient and home services	10% after annual deductible	Annual deductible plus the difference between the BCBSM approved amount and the provider's charge

The exam, diagnosis and treatment of an injury, illness or disease by a physician is payable when you are seen in:

- A physician's office
- Outpatient clinic
- Outpatient department of a hospital
- The home
- Urgent care setting

Chiropractic services

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
10% after annual	10% after annual	10% after annual

deductible	deductible	deductible

Your coverage for chiropractic services includes the following:

- One new patient office call every 36 months and one established patient office call each calendar year

  A new patient is one who has not been seen by the same provider in 36 months.
- Chiropractic manipulation limited to one per day, 24 visits per calendar year
- X-rays for accidental injuries
- Limited physical therapy
- Chiropractic traction

Hearing care

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
$0	$0	100%

Your hearing care coverage is designed to identify hearing problems and provide benefits for corrective hearing devices.

Choosing your hearing provider

When you need hearing care, it’s important to find out whether your provider participates with BCBSM because hearing benefits are covered only when services are received from a participating provider.

The types of eligible hearing providers include:

- Audiologists
- Otologists
- Otolaryngologists

To locate a Blues participating hearing care provider in Michigan, call the State of Michigan Customer Service Center at **1-800-843-4876**.

Out-of-state providers who participate with their local Blues Plans are paid the BCBSM-approved amount. Out-of-state providers who do not participate with their local Blues Plans are paid the reasonable and customary charges made by the individual provider.

What's covered under your hearing care benefits

Hearing care benefits are available only after you receive a medical clearance examination by a physician (MD or DO) to rule out the presence of a medical condition. There is a $10 copayment for the medical clearance exam.

Then, within six months, you must receive the following services from a **participating provider in the order listed**:

1. **Audiometric examination** — Measures hearing ability, including tests for air and bone conduction, speech reception and speech discrimination
2. **Hearing aid evaluation** — Determines what type of hearing aid should be prescribed to compensate for loss of hearing
3. **Ordering and fitting of the hearing aid** — Includes in-the-ear, behind-the-ear, and basic hearing aids worn on the body, with ear molds, if necessary, as well as dispensing fees for the normal services required for fitting the hearing aid
4. **Conformity test** — Evaluates the performance of a hearing aid and its

conformity to the original prescription after it has been fitted

Time limitation

Hearing care benefits are payable once every 36 months unless significant hearing loss occurs earlier and is certified by your physician.

What's not covered under your hearing care benefit

Your hearing care coverage **does not** cover:

- Your medical clearance examination to determine possible loss of hearing
- A hearing aid ordered while the patient is a member, but delivered more than 60 days after the patient's coverage terminates
- Replacement of hearing aids that are lost or broken, unless this occurs after 36 months, when benefits are renewed
- Repairs and replacement of parts including batteries and ear molds
- Additional charges for eye-glass type hearing aids (sometimes called "deluxe" hearing aids) that exceed the amount BCBSM pays for a basic hearing aid
- Additional charges for digital-controlled programmable hearing devices (sometimes called "deluxe" hearing aids) that exceed the amount BCBSM pays for a basic hearing aid
- Additional charges for unusual or cosmetic equipment such as canal, one-half shell or low profile hearing aids (sometimes called "deluxe" hearing aids) that exceed the amount BCBSM pays for a basic hearing aid
- All hearing care services and supplies provided by a **nonparticipating provider in Michigan**
- Hearing aids that do not meet Food and Drug Administration and Federal Trade Commission requirements

Alternatives to hospital care

Home Hemodialysis Program

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
Annual deductible	10% after annual deductible	100%

Hemodialysis services are covered in the home. Your physician must arrange for home hemodialysis and all services must be billed by a participating hospital that has an approved hemodialysis program. Benefits include:

- Cost of the equipment
- Installation
- Training
- Necessary hemodialysis supplies

Home Hemophilia Program

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
Annual deductible	10% after annual deductible	100%

This benefit allows you to receive in-home treatment for hemophilia. Your

physician must prescribe all services and supplies and they must be billed by a participating hospital. Benefits include:

- All medications, including the antihemophilic factor
- Necessary hemophilia supplies, including syringes and needles
- Training of the patient or a family member on how to inject the antihemophilic factor when the training is provided through an approved facility

Home Health Care Program

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
Annual deductible	Annual deductible	100% after annual deductible

Your home health care benefit covers unlimited visits when the service is provided by a participating home health care agency and preauthorized by BCBSM.

Preauthorization is a process that allows physicians and other professional providers to determine, before treating a patient, if BCBSM will cover the cost of a proposed service.

The physician must certify that the patient is confined to the home due to illness and that home health care services are being used instead of inpatient hospital care. The physician must also prescribe and submit a detailed treatment plan to the agency. Once the agency accepts the patient into its program, the following services are covered when billed by the agency:

- Home health aide services if the patient is receiving skilled nursing care or physical or speech therapy and the health care agency has identified a need for the patient to have these services

  These services may include assistance with activities of daily living such as bathing, dressing, meal preparation and feeding.
- Social services and nutritional guidance when requested by the patient's physician
- Physical, speech and occupational therapy
- Nursing care by a licensed practical nurse or a licensed vocational nurse when the services of a registered nurse are unavailable

To obtain preauthorization, your physician or home health care agency must contact the BCBSM Integrated Medical and Surgical Services department. The department is open Monday through Friday from 8 a.m. to 5 p.m., Eastern time. The telephone number is **1-800-482-4040**.

The State Health Plan *PPO* does **not** pay for:

- General housekeeping services
- Cost of meals
- Transportation to or from a hospital or other facility
- Elastic stockings, including nonprescription compression socks
- Sheepskin
- Comfort items such as lotion, mouthwash or body powder
- Physician services
- Custodial or nonskilled care

CALL-OUT BOX
Your home health care benefit covers unlimited visits when the service is provided by a participating home health care agency and preauthorized by

BCBSM.

Skilled nursing care

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
Annual deductible	Annual deductible	100%

Members have 120 skilled nursing days per admission. Care must be received in a BCBSM-approved skilled nursing facility and the following conditions must be met:

- The patient is suffering from or gradually recovering from an illness or injury.
- The patient is expected to improve.
- The admission has been preauthorized by BCBSM.

Your benefit includes coverage for:

- Semi-private room
- Meals and special diets
- Nursing services
- Use of special treatment rooms
- X-ray and laboratory examinations
- Physical, speech and occupational therapy
- Oxygen and other gas therapy
- Drugs, biologicals and solutions
- Materials used in dressings and casts

The benefit renews 90 days after discharge.

To obtain preauthorization, your physician or skilled nursing facility must contact the BCBSM Integrated Medical and Surgical Services department. The department is open Monday through Friday from 8 a.m. to 5 p.m., Eastern time. The telephone number is **1-800-482-4040**.

Written confirmation of the need for skilled care is required from the patient's physician. All services must be provided at a participating skilled nursing facility.

The State Health Plan *PPO* does **not** pay for:

- Custodial care
- Care for senility or mental retardation
- Care for substance abuse
- Care for long-term mental illness

Coordinated Care Management

What you pay for covered services
Payment is determined by type of service provided.

Coordinated Care Management is a voluntary service through which care is provided outside a hospital setting. Also known as disease management, CCM is designed to improve certain chronic conditions.

The program features two levels of care, and a patient's placement within one of them depends on the severity of his or her condition.

Level 1 is reserved for more severe cases, defined by the patient

experiencing some type of major health event such as a heart attack or a hospital admission due to asthma.

Level 2 is for patients who have not experienced a major health event and are considered to be at moderate to low risk.

How it works

Patients in the program are assigned a nurse care manager who conducts a health assessment and works with the patient and his or her physician to design an individualized treatment plan. Examples of treatment goals include reducing risk factors and making lifestyle changes.

Once the treatment plan is implemented, the care manager coordinates the services. As the patient makes progress, the treatment goals will change and may, for example, focus on patient education and the development of skills to help the patient take charge of his or her health.

Who qualifies

To qualify for level 1, the patient must have had one or more inpatient admissions in the past nine months, one or more emergency room visits related to their disease in the past six months, or a referral from a physician for:

- Asthma
- Diabetes
- Congestive heart failure
- Ischemic heart disease

Any patients not meeting level 1 criteria or those who choose not to participate in level 1 can participate in level 2.

Patients can refer themselves or be referred by a friend, family member or benefit representative.

For more information about Coordinated Care Management, please call **1-800-768-6787**. Representatives are available Monday through Friday from 8 a.m. to 5 p.m. Eastern time.

Hospice care

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
$0 up to lifetime maximum	$0 up to lifetime maximum	100%

A hospice is an agency or facility that is primarily involved in providing care to terminally ill individuals. Hospice care can be an alternative to hospitalization. To be eligible for hospice care:

- The attending physician must certify in writing that life expectancy is six months or less.
- The patient must choose hospice care instead of inpatient services.
- The care must be provided by a Medicare or BCBSM-certified hospice program that is approved for both Medicare and non-Medicare enrollees.

You may apply for hospice care benefits only after discussion with and referral by your attending physician and your request must be in writing to the hospice agency.

Electing hospice benefits

When the patient elects to enter the program, the hospice benefits will

replace the patient's State Health Plan *PPO* benefits for conditions relating to the terminal illness. The hospice benefits will be more specific to the patient's needs and may include alternative services that provide more appropriate care. However, services for medical conditions **unrelated** to the terminal illness are covered according to your State Health Plan *PPO* coverage.

The patient may cancel, in writing, all hospice benefits at any time. When services are canceled, the patient's regular coverage resumes.

Hospice services

The lifetime maximum of your hospice benefit is adjusted annually by the State. Please call the BCBSM State of Michigan Customer Service Center at **1-800-843-4876** for the current amount.

The following benefits are payable under the hospice program:

- Nursing care when provided by or under the supervision of a registered nurse
- Home health aide and homemaker services
- Medical social services including needs assessment and psychological and dietary counseling when provided by a qualified social worker under the supervision of a physician
- Counseling services for the patient and caregivers, when care is provided in the home. This includes bereavement counseling for the family up to 30 days after the patient's death
- Medical appliances and supplies furnished to lessen the effects of the terminal illness
- Durable medical equipment for use in the patient's home when furnished by the hospice program
- Physical, speech and occupational therapy when provided to control symptoms and maintain the patient's daily activities and basic functional

skills

The following services are **not** covered:

- Costs of transportation
- Funeral arrangements
- Financial or legal counseling
- Pastoral counseling
- Estate planning

Physical, occupational and speech therapy

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
Annual deductible	10% after annual deductible	Annual deductible plus the difference between the BCBSM approved amount and the provider's charge

Your benefit covers physical, occupational and speech therapy for 60 days per calendar year.

Physical therapy is the use of specific activities or methods to treat a disability when there is a loss of neuromusculoskeletal function due to an illness, injury or following surgery.

Physical therapy is payable when provided in:

- The outpatient department of a participating hospital
- Participating outpatient physical therapy facilities
- Physicians' offices
- Independent licensed physical therapists' offices
- In the home if part of a home health care treatment plan

Physical therapy must require the assistance and supervision of the appropriate licensed therapist and it must be:

- Prescribed by the patient's attending physician

- Designed to improve or restore the patient's functioning level after a loss in musculoskeletal functioning due to an illness or injury
- Provided for a condition that is capable of significant improvement in a reasonable and generally predictable period of time

Examples of covered services are:

- Therapy prescribed to restore musculoskeletal functioning
- Therapy used in conjunction with a treatment program to accelerate the healing of an acute injury or illness involving the muscles or joints

Occupational therapy is a rehabilitative service that uses specific activities or methods to:

- Develop, improve or restore the performance of necessary neuromusculoskeletal functions affected by an illness, injury or following surgery
- Help the patient learn to apply the newly restored or improved function to meet the demands of daily living

It's payable when provided in the outpatient department of a participating hospital.

Speech and language pathology services are rehabilitative services that use a specific activity or method to treat speech, language, swallowing or voice impairment due to an illness, injury or following surgery.

Your benefit covers therapy for:

- Nondevelopmental speech disorders, which are characterized by a communicative loss caused by trauma or organic conditions such as aphasia following a stroke or dysphonia resulting from vocal cord surgery

- Severe congenital and developmental speech disorders, which are characterized by severe communicative deficits as a result of congenital (present at or existing from birth) and developmental conditions, for children age 6 and under

Speech and language pathology services are payable when provided in the outpatient department of a participating hospital.

Your coverage for physical, occupational and speech therapy does **not** pay for:

- Long-standing, chronic conditions such as arthritis
- Health club membership or spa membership
- Massage therapy
- Developmental conditions or learning disabilities
- Congenital or inherited speech abnormalities
- Inpatient hospital admissions principally for speech or language therapy

Physical therapy, occupational therapy and speech and language pathology services are paid based on location and diagnosis. To avoid incurring expenses for services that are not payable, we recommend you call or write the BCBSM State of Michigan Customer Service Center before receiving the service.

CALL-OUT BOX
Physical therapy, occupational therapy and speech and language pathology services are paid based on location and diagnosis. To avoid incurring expenses for services that are not payable, we recommend you call or write the BCBSM State of Michigan Customer Service Center before receiving the service.

Durable medical equipment

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
10% after annual deductible	10% after annual deductible	Annual deductible plus the difference between the BCBSM approved amount and the provider's charge

Your benefit covers durable medical equipment when the equipment is appropriate for home use and prescribed by a physician. The prescription must include a description of the equipment and a diagnosis. When these criteria are met, your benefit allows for:

- **Renting equipment** — For rental equipment, a new prescription must be written when the current prescription expires.

  If the rental fee exceeds the purchase price based on your physician's estimated duration of need, you'll be advised to purchase rather than rent the equipment.
- **Purchasing equipment** — Your benefit includes purchasing equipment only when it is less expensive than continued rental. The purchase of new and used equipment is covered provided the equipment is purchased only from a professional supplier.
- **Repairing equipment** — Repair costs are covered on purchased equipment when the condition is due to normal wear and tear.
- **Replacing equipment** — The replacement of purchased equipment is covered when there is loss or irreparable damage of your equipment or a change in your condition or size.
- **Contraceptive devices** — Covers one per year physician-

prescribed contraceptive devices such as diaphragms or IUDs, and their insertion.

The following are **not** covered:

- Nonmedical equipment
- Exercise and hygienic equipment
- Comfort and convenience items
- Self-help devices such as elevators
- Deluxe equipment, such as motorized wheelchairs, unless medically necessary and required so the patient can operate the equipment themselves
- Routine maintenance expenses, such as the cost of batteries
- Experimental or investigational equipment

If you have questions about whether a certain piece of equipment is covered, please write to the BCBSM State of Michigan Customer Service Center.

Please include:

- Information about your condition or diagnosis
- A copy of your physician’s prescription
- The name and description of the prescribed equipment

A BCBSM representative will contact you if additional information is required.

Prosthetic and orthotic appliances

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
10% after annual deductible	10% after annual deductible	Annual deductible plus the difference between the BCBSM approved amount and the provider's charge

Your benefit covers prosthetic and orthotic appliances when they're prescribed by a physician and supplied by a licensed orthotist or prosthetist. Benefits include:

- Prosthetic and orthotic appliances that are prefabricated, custom-fitted and made
- Temporary appliances
- Delivery, services and fitting charges
- Repair of covered appliances
- Adjustment or replacement of appliances when they are damaged beyond repair because of wear, growth or change in the patient's condition or size

Braces do not have to be attached to a shoe.

If you have questions about whether a certain appliance will be covered, you should send a written inquiry to the BCBSM State of Michigan Customer Service Center.

Please include:

- Information about your condition or diagnosis
- A copy of your physician’s prescription
- The name and description of the prescribed equipment

A BCBSM representative will contact you if additional information is required.

Human organ transplants

The State Health Plan *PPO* covers certain human organ and tissue transplants when they are received at a participating hospital or, where noted, in a BCBSM-approved transplant facility, designated transplant facility or designated cancer center.

In some cases, BCBSM must approve the transplant.

Organ and tissue transplants

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
Annual deductible	10% after annual deductible	100%

Benefits are payable for services performed to obtain, store and transplant the following human tissues and organs:

- Cornea
- Kidney
- Skin
- Bone marrow (as described below)

The State Health Plan *PPO* will pay for covered services for donors if the donor does not have transplant benefits under any other health care plan.

Bone marrow transplants

What you pay for covered services		
In-network	**Out-of-network**	**Nonparticipating**
Annual deductible	10% after annual deductible	100%

Bone marrow transplants involve replacing the bone marrow of a patient with bone marrow or peripheral blood stem cells. The replacement bone marrow may be from a donor (an **allogeneic** transplant) or removed from you before treatment and then returned (an **autologous** transplant).

Bone marrow transplants are only covered when the transplant is pre-approved, or what we call “preauthorized,” by BCBSM and must be received at a BCBSM-designated transplant facility.

Preauthorization is a process that allows physicians and other professional providers to determine, before treating a patient, if BCBSM will cover the cost of a proposed service.

Benefits for **allogeneic** transplants are payable only to treat the following conditions when the transplant is **not** considered experimental or investigational for the condition being treated:

- Acute lymphocytic leukemia
- Acute non-lymphocytic leukemia
- Aplastic anemia
- Beta Thalassemia, major
- Chronic myeloid leukemia
- Hodgkin’s disease (relapsed and stage III or IV)
- Hurler’s syndrome
- Myelodysplastic syndromes

- Myelofibrosis
- Neuroblastoma (stage III or IV)
- Non-Hodgkin’s lymphoma (intermediate or high grade)
- Osteopetrosis
- Severe combined immune deficiency disease (SCID)
- Sickle cell disease (when complicated by stroke)
- Wiskott-Aldrich syndrome

Benefits for **autologous** transplants are payable only to treat the following conditions when the transplant is **not** considered experimental or investigational for the condition being treated:

- Acute lymphocytic leukemia
- Acute non-lymphocytic leukemia
- Ewing’s sarcoma
- Germ cell tumors of ovary, testis, mediastinum and retroperitoneum
- Hodgkin’s disease (stage III or IV)
- Medulloblastoma
- Metastatic breast cancer (stage IV)
- Multiple myeloma
- Neuroblastoma (stage III or IV)
- Non-Hodgkin’s lymphoma (intermediate or high grade)
- Primitive neuroectodermal tumors
- Wilms’ Tumor

Specified human organ transplants

What you pay for covered services		
Designated facility	**Out-of-network**	**Nonparticipating**
Annual deductible	100%	100%

“Specified” human organ transplants are only covered when the transplant is pre-approved, or what we call “preauthorized,” by BCBSM and must be received at a BCBSM-designated transplant facility.

Preauthorization is a process that allows physicians and other professional providers to determine, before treating a patient, if BCBSM will cover the cost of a proposed service.

The transplant facility or your physician **must** request preauthorization from BCBSM before surgery.

Specified transplants include transplants of the:

- Liver
- Partial liver (a portion of the liver taken from a brain-dead or living donor)
- Heart
- Lungs
- Lobar lung (transplantation of a portion of a lung from a brain dead or living donor)
- Heart-lungs
- Pancreas
- Simultaneous pancreas-kidney
- Small intestine (small bowel)
- Combined small bowel-liver

All payable human organ transplant services, except anti-rejection drugs and other transplant-related prescription drugs, must be provided during the benefit period. The benefit period begins five days before, and ends one year after, the organ transplant.

The total payment for all services combined for each specified organ transplant type is limited by a $1 million lifetime maximum.

Please call the BCBSM Human Organ Transplant Program for additional information on human organ transplants. The hours of operation are Monday through Friday from 8 a.m. to 5 p.m. The telephone number is **1-800-242-3504**.

Other covered services

What you pay for covered services unless otherwise noted		
In-network	**Out-of-network**	**Nonparticipating**
Annual deductible	10% after annual deductible	Annual deductible plus the difference between the BCBSM approved amount and the provider's charge

Your coverage also includes the following services:

- **Insulin pumps**
- **Blood** — Includes the cost of drawing and storing self-donated blood intended for your scheduled surgery
- **Oxygen and other therapeutic gases** — Oxygen, and equipment to administer the oxygen, are covered when prescribed by a physician and medically necessary.
- **Medical supplies** — Medical supplies and dressings for use in the home, are covered when prescribed by a physician for the treatment of a specific medical condition.
- **Wigs** — You have a lifetime maximum of $300 for wigs, wig stands and supplies, such as adhesives. This benefit is for those who need wigs because of cancer or alopecia. There is no deductible or copayment up to the $300 lifetime maximum.

  Additional replacements for children due to growth are available.
- **Dental services to treat accidental injuries** — An external force must have caused the injury. Injuries resulting from biting or chewing are not covered.

- **Specified oncology clinical trials** — Covers antineoplastic drugs for the treatment of stages II and III breast cancer and all stages of ovarian cancer when they're provided following an approved phase II or III clinical trial

  This benefit does not limit or preclude coverage of antineoplastic drugs when Michigan law requires these drugs, and the reasonable cost of their administration, be covered. Payment is determined by services provided.

  For services to be covered, the following requirements must be met:

  — The inpatient admission and length of stay must be medically necessary and preapproved. No retroactive approvals will be granted.

  — The services must be performed at a National Cancer Institute-designated cancer center or an affiliate of an NCI-designated center.

  — The treatment plan, also called "protocol," must meet the guidelines of the February 19, 1993, American Society of Clinical Oncology statement for clinical trials.

  — The patient must be an eligible Blue Cross Blue Shield of Michigan member with hospital, medical and surgical coverage.

  If these requirements are not met, the services will not be covered and you will be responsible for all charges.

  Please call the State of Michigan Customer Service Center at 1-800-843-4876 for additional information on specified oncology clinical trials.

- **Eye and ear examinations** – Covered for the diagnosis and treatment of an illness, injury or disease, including medical clearance examinations

  There is a $10 fixed dollar copayment for medical clearance examinations.

- **Optical services following cataract surgery** — Your benefits include

the examination and fitting of one pair of contact lenses when prescribed by a physician following cataract surgery and obtained within one year of the surgery. Cataract sunglasses are not covered.

- **Chelation therapy** — Payable based on certain medical guidelines and diagnoses

  To avoid incurring expenses for chelation therapy services that are not payable, we recommend you call or write the BCBSM State of Michigan Customer Service Center before receiving the service.

- **Private duty nursing** – Covered when the patient's condition requires 24-hour, continuous skilled care by a professional nurse on a one-to-one basis

  Nonskilled care or care provided by a nurse who ordinarily resides in the patient's home or is a member of the immediate family is **not** covered.

  Services must be prescribed by a physician and provided by a registered or licensed practical nurse. The attending physician must complete a certification statement each month the patient is required to have private duty nursing care.

  To avoid incurring expenses for private duty nursing services that aren't payable, we recommend you call or write the BCBSM State of Michigan Customer Service Center before receiving private duty nursing services.

- **Weight Loss Benefit** — Benefits are available for nonmedical weight reduction up to a lifetime maximum of $300.
- **Injections** — Fluids that are forced into a vein or body organ or under the skin to fight disease are payable.
- **Rabies treatment** — Rabies treatment is a benefit after the initial emergency room treatment.
- **Cardiac Rehabilitation**
- **Diabetic training**
- **Contraception Devices** — Includes Depo Provera injections

What's not covered under the State Health Plan PPO

The following services are not covered under the State Health Plan *PPO*:

- Care and services available at no cost to you in a veteran, marine or other federal hospital or any hospital maintained by any state or governmental agency
- Medically necessary services received on an inpatient basis that can be provided safely in an outpatient or office location
- Custodial care, rest therapy and care in nursing or rest home facilities
- Dental surgery other than for the removal of impacted teeth or multiple extractions when the patient must be hospitalized for the surgery because a concurrent medical condition exists
- Treatment of Temporomandibular Joint Syndrome and related jaw-joint problems by any method other than as specified in this benefit book
- Hospital admissions that begin **before** the effective date of coverage
- Hospital admissions that begin **after** the coverage termination date
- Medical services or supplies provided or furnished **before** the effective date of coverage or **after** the coverage termination date
- Health care services provided by persons who are not legally qualified or licensed to provide such services
- Routine hospital outpatient care requiring repeated visits for the treatment of chronic conditions
- Hospitalization principally for:

  — Observation

— Diagnostic evaluation

— Physical therapy

— X-ray or lab tests

— Reduction of weight by diet control (with or without medication)

— Basal metabolism tests

— Electrocardiography

- Items for the personal comfort or convenience of the patient
- Premarital or pre-employment exams
- Reverse sterilization
- Services and supplies that are not medically necessary according to accepted standards of medical practice
- Treatment of occupational injury or disease that the State of Michigan is obligated to furnish or otherwise fund
- Care and services received under another certificate offered by BCBSM or another Blue Cross Blue Shield Plan
- Care and services payable by government-sponsored health care programs, such as Medicare or TRICARE, formerly CHAMPUS, for which a member is eligible

  These services are not payable even if you have not signed up to receive the benefits provided by such programs.
- Cosmetic surgery and related services solely for improving appearance, except as specified in this handbook
- Treatment of a condition caused by military action or war, declared or undeclared
- Services, care, devices or supplies considered experimental or investigative
- Services for which a charge is not customarily made
- Services for which the patient is not obligated to pay or services

without cost

- Dialysis services after 33 months of ESRD treatment
- Services that are not included in your plan coverage documents
- Transportation and travel except as specified in this benefit book
- Services rendered for gender reassignment

Filing claims

When you use your benefits, a claim must be filed before payment can be made. PPO network providers and Blues participating providers should automatically file all claims for you. All you need to do is show your BCBSM ID card. However, if you receive services from nonparticipating providers, they may or may not file a claim for you.

To file your own claim, follow these steps:

1. Ask your provider for an **itemized** statement with the following information:
   - Patient's name and birth date
   - Subscriber's name, address, phone number and contract number (from your BCBSM ID card)
   - Provider's name, address, phone number and federal tax ID number
   - Date and description of services
   - Diagnosis (nature of illness or injury) and procedure code
   - Admission and discharge dates for hospitalization
   - Charge for each service
2. Make a copy of all items for your files. You'll also need to complete a *claim* form. To obtain a form, call the BCBSM State of Michigan Customer Service Center at **1-800-843-4876**.
3. Mail the claim form and itemized statement to the State of Michigan Customer Service Center.

Please file claims promptly because most services have a 15-month filing limitation.

You'll receive payment directly from BCBSM. The check will be in the subscriber's name, not the patient's name.

Filing claims for services received outside the United States

Submit claims as noted above for services received outside the United States, using the guidelines under the Choosing a Network Provider—Care Out of the Country section of this book.

Your right to file an internal grievance

Most questions or concerns about how we processed your claim or request for benefits can be resolved through a phone call to one of our customer service representatives. However, Michigan Public Act 350, as amended by Public Act 516 of 1996 and Public Act 250 of 2000, protects you by providing an internal grievance procedure, including a managerial-level conference, if you believe that we have violated **Section 402 or 403 of Public Act 350**. You will find the specific provisions of those two parts of the act at the end of this section.

Internal grievances

Standard internal grievance procedure

Under the standard internal grievance procedure, we must provide you with our final written determination within 35 calendar days of our receipt of your written grievance. However, that timeframe may be suspended for any amount of time that you are permitted to take to file your grievance, and for a period of up to 10 days if we have not received information we have requested from a health care provider — for example your doctor or hospital. The standard internal grievance procedure is as follows:

- You or your authorized representative must send us a written statement explaining why you disagree with our determination on your request for benefits or payment.

  Mail your written grievance to the address found in the top right hand corner of the first page of your Explanation of Benefits Payments statement or to the address contained in the letter we send you to notify you that we have not approved a benefit or service you are requesting.

  We will respond to your grievance in writing. If you agree with our

response, it becomes our final determination and the grievance ends.

- If you disagree with our response to your grievance, you may then request a managerial-level conference. You must request the conference in writing.

  Mail your request to:

  Conference Coordination Unit
  Blue Cross Blue Shield of Michigan
  P.O. Box 2459
  Detroit, MI 48231-2459

  You can ask that the conference be conducted in person or over the telephone. If in person, the conference can be held at our headquarters in Detroit or at a local customer service center. Our written proposed resolution will be our final determination regarding your grievance.

- In addition to the information found above, you should also know:

  — You may authorize in writing another person including, but not limited to, a physician to act on your behalf at any stage in the standard internal grievance procedure.

  — Although we have 35 days within which to give you our final determination, you have the right to allow us additional time if you wish.

  — You may obtain copies of information relating to our denial, reduction or termination of coverage for a health care service for a reasonable copying charge.

Expedited internal grievance procedure

If a physician substantiates orally or in writing that adhering to the time frame for the standard internal grievance would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, you may file a request for an expedited internal grievance. **You may file a request for an expedited internal grievance only when you think that**

we have wrongfully denied, terminated or reduced coverage for a health care service *prior* to your having received that health care service or if you believe we have failed to respond in a timely manner to a request for benefits or payment.

The procedure is as follows:

- You may submit your expedited internal grievance request by telephone. The required physician's substantiation that your condition qualifies for an expedited grievance can also be submitted by telephone.

  Call the expedited grievance hot line: (313) 225-6800

  We must provide you with our decision within **72 hours** of receiving both your grievance and the physician's substantiation.
- In addition to the information found above, you should also know:
  - — You may authorize in writing another person including, but not limited to, a physician to act on your behalf at any stage in the expedited internal grievance procedure.
  - — If our decision is communicated to you orally, we must provide you with written confirmation within two business days.

Sections 402 and 403 of Public Act 350

What we may not do

The sections below provide the exact language in the law.

Section 402(1) provides that we may not do any of the following:

- Misrepresent pertinent facts or certificate provisions relating to coverage
- Fail to acknowledge promptly or to act reasonably and promptly upon

communications with respect to a claim arising under a certificate

- Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate
- Refuse to pay claims without conducting a reasonable investigation based upon the available information
- Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received
- Fail to attempt in good faith to make a prompt, fair and equitable settlement of a claim for which liability has become reasonably clear
- Compel members to institute litigation to recover amounts due under a certificate by offering substantially less than the amounts due
- Attempt to settle a claim for less than the amount which a reasonable person would believe was due under a certificate, by making reference to written or printed advertising material accompanying or made part of an application for coverage
- Make known to the member administrative hearing decisions in favor of members for the purpose of compelling a member to accept a settlement or compromise in a claim
- Attempt to settle a claim on the basis of an application that was altered without notice to, knowledge or consent of the subscriber under whose certificate the claim is being made
- Delay the investigation or payment of a claim by requiring a member, or the provider of health care services to the member, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification
- Fail to promptly provide a reasonable explanation of the basis for a denial of a claim or for the offer of a compromise settlement
- Fail to promptly settle a claim where liability has become reasonably clear under one portion of the certificate in order to influence a settlement under another portion of the certificate

Section 402(2) provides that there are certain things that we cannot do in order to induce you to contract with us for the provision of health care benefits, or to induce you to lapse, forfeit or surrender a certificate issued by us or to induce you to secure or terminate coverage with another insurer, health maintenance organization or other person.

The things we cannot do under this section are:

- Issue or deliver to a person money or other valuable consideration
- Offer to make or make an agreement relating to a certificate other than as plainly expressed in the certificate
- Offer to give or pay, directly or indirectly, a rebate or part of a premium, or an advantage with respect to the furnishing of health care benefits or administrative or other services offered by the corporation except as reflected in the rate and expressly provided in the certificate
- Make, issue or circulate, or cause to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of a certificate or contract for administrative or other services, the benefits thereunder, or the true nature thereof
- Make a misrepresentation or incomplete comparison, whether oral or written, between certificates of the corporation or between certificates or contracts of the corporation and another health care corporation, health maintenance organization or other person

What we must do

Section 403 provides that we must, on a timely basis, pay to you or a participating provider benefits as are entitled and provided under the applicable certificate. When not paid on a timely basis, benefits payable to you will bear simple interest from a date 60 days after we have received a satisfactory claim form at a rate of 12 percent interest per year. The interest will be paid in addition to the claim at the time of payment of the claim.

We must specify in writing the materials which constitute a satisfactory claim form no later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form will be considered to be paid on a timely basis if paid within 60 days after we receive the claim form.

Other general information

Coordination of benefits

Coordination of benefits is how group health care plans and insurance carriers coordinate benefits when members are covered by more than one plan. Under COB, group health care plans and insurance carriers work together to make sure members receive the maximum benefits available under their plans. Your State Health Plan *PPO* requires that your benefit payments be coordinated with those from another group plan for services that may be payable under both plans.

COB ensures that the level of payment, when added to the benefits payable under another group plan, will cover up to 100 percent of the eligible expenses as determined between the group health care plans. In other words, COB can reduce or eliminate out-of-pocket expenses for you and your family. COB also makes sure that the combined payments of all coverage will not exceed the approved cost for care.

How COB works

When a patient has double coverage, BCBSM determines who should pay before processing the claim. If the State Health Plan *PPO* is primary, then full benefits under the plan will be paid. If the State Health Plan *PPO* is secondary, payment towards the balance of the cost of covered services — up to the total allowable amount determined by both group plans — will be paid.

The guidelines used to determine which plan pays first are as follows:

- If a group health plan does not have a coordination of benefits provision, that plan is primary.

- If husband and wife have their own coverage, the husband's health coverage is primary when he receives services and the wife's coverage is primary when she receives services.
- If a child is covered under both the mother's and the father's plan, the plan of the parent (or legal guardian) whose birthday is earlier in the year is primary.
- If the child's parents are divorced, benefits will be paid according to any court decree. If no such decree exists, benefits are determined in the following order unless a court order places financial responsibility on one parent:

  1. Custodial parent
  2. Stepparent (if remarried)
  3. Noncustodial parent
  4. Noncustodial stepparent (if remarried)

  If the primary plan cannot be determined by using the guidelines above, then the plan covering the child the longest is primary.

Processing your COB claims

When we receive your claim, we determine which plan is primary. Then we process your claim as follows:

- If we are primary, we pay for covered services up to the maximum amount allowed under your benefit plan, less any deductible or copays.
- If the other health plan is primary, we will return the claim to your provider, indicating that we are not primary, so your provider can bill the other group health plan. We'll also send you an *Explanation of Benefit Payments* form that tells you we have billed another carrier.
- If we are both primary and secondary, we'll process your claim first under the primary plan, and then **automatically process the same claim** under the secondary plan.

- If we are secondary and the primary plan has already paid, either you or your provider can submit a claim to us for consideration of any balances. Be sure to include the EOBP form you received from your primary plan.

Please make copies of all forms and receipts for your files.

Keeping your COB information updated

After enrollment, we'll periodically send you a COB questionnaire to update your coverage information. Please complete and return this questionnaire so that we can continue processing your claims without delay.

Subrogation

Occasionally, another person, insurance company or organization may be legally obligated to pay for health care services that we have paid. When this happens:

- Your right to recover payment from them is transferred to BCBSM.
- You're required to do whatever is necessary to help BCBSM enforce their right of recovery.

If you receive money through a lawsuit, settlement or other means for services paid under your coverage, you must reimburse BCBSM. However, this does not apply if the funds you receive are from additional health coverage you purchased in your name from another insurance company.

Medicare and Supplemental coverage

Medicare is a federal health care benefit program for people who are:

- Age 65 or older (except for certain pension recipients and spouses covered under the State Police Retirement System)
- Diagnosed with End Stage Renal Disease (Please see the Hemodialysis heading in the Hospital Coverage section of this book.)
- Under age 65 but have received a Social Security disability benefit for at least 24 months

The State Health Plan *PPO* is primary, which means it pays first, for actively working employees and their enrolled dependents. However, Medicare will become primary for actively working employees and their enrolled dependents with End Stage Renal Disease after 33 months, and the State Health Plan *PPO* will act as a supplement to Medicare coverage.

Medicare coverage for inpatient and physician services

Medicare has two parts: Part A and Part B. Part A helps pay for inpatient hospital care and certain follow-up care after you leave the hospital. It's provided to you at no cost.

Part B helps pay for physician's services and other medical services and items. There is a monthly premium that you must pay for Part B coverage.

The State Health Plan *PPO* supplements Part A by covering services that Medicare doesn't — as long as those services are benefits under the State Health Plan *PPO*. It supplements Part B by covering 20 percent of

Medicare's reasonable charge for services. You're still responsible for any applicable deductible and copayment.

If you don't enroll in Part B of Medicare, your State Health Plan *PPO* coverage will be adjusted as if Medicare coverage were in place. The State Health Plan *PPO* will not reimburse that portion of expenses normally covered by Medicare. This may result in limited payment or no payment.

Enrolling in Medicare

Enrollment in Medicare is handled in two ways: either you are enrolled automatically or you have to apply. Here's how it works:

Automatic enrollment

If you are not yet 65 and already getting Social Security you do not have to apply for Medicare. You will be enrolled automatically in both Part A and Part B effective the month you are 65. Your Medicare card will be mailed to you about three months before your 65th birthday.

If you are disabled and have been receiving disability benefits under Social Security for 24 months, you will be automatically enrolled in Part A and Part B beginning the 25th month of benefits. Your card will be mailed to you about three months before your entitlement.

Remember that if you don't enroll in Part B of Medicare, your State Health Plan *PPO* coverage will be adjusted as if Medicare coverage were in place. The State Health Plan *PPO* will not reimburse that portion of expenses normally covered by Medicare. This may result in limited payment or no payment.

Applying for Medicare

You should apply for Medicare three months before the month you turn 65. This is the beginning of your seven-month initial enrollment period. If you wait until you are 65, or in the last three months of your initial enrollment

period, your Part B coverage will be delayed. You can apply for Medicare through your local Social Security Administration office.

If you do not enroll in Part B during your initial enrollment period, you will have to wait until the next general enrollment period to enroll. General enrollment periods are held January 1 through March 31 of each year, and Part B coverage starts on July 1 of that year. Your Part B premium will go up 10 percent for each 12-month period that you have been eligible for Part B but did not take it.

Remember that if you don't enroll in Part B of Medicare, your State Health Plan *PPO* coverage will be adjusted as if Medicare coverage were in place. The State Health Plan *PPO* will not reimburse that portion of expenses normally covered by Medicare. This may result in limited payment or no payment.

You can get more information on Medicare by logging on to the Medicare Web site at **www.medicare.gov**.

CALL-OUT BOX

If you don't enroll in Part B of Medicare, your State Health Plan *PPO* coverage will be adjusted as if Medicare coverage were in place. The State Health Plan *PPO* will not reimburse that portion of expenses normally covered by Medicare. This may result in limited payment or no payment.

Glossary

Accidental injury is physical damage caused by an action, object or substance outside the body. This includes:

- Strains
- Sprains
- Cuts and bruises
- Allergic reactions
- Frostbite
- Sunburn and sunstroke
- Swallowing poison
- Medication overdosing
- Inhaling smoke, carbon monoxide or fumes

Acute care facility is a facility that offers a wide range of medical, surgical, obstetric and pediatric services. These facilities primarily treat patients with conditions that require a hospital stay of less than 30 days. The facility is **not** primarily for:

- Custodial, convalescent or rest care
- Care of the aged
- Skilled nursing care or nursing home care
- Substance abuse treatment

Adequate access is defined by how far you live from PPO providers and hospitals. The State Health Plan *PPO* access standards are as follows:

- Two family care physicians within 15 miles of your home
- Two specialty care physicians within 20 miles of your home

- One hospital within 25 miles of your home

Allogeneic (Allogenic) transplant is a procedure using another person's bone marrow or peripheral blood stem cells to transplant into the patient (including syngeneic transplants when the donor is the identical twin of the patient).

Ambulatory surgery facility is a separate outpatient facility that is not part of a hospital, where surgery is performed and care related to the surgery is given. The procedures performed in this facility can be performed safely without overnight inpatient hospital care.

Approved amount is the BCBSM maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles and copays are deducted from the approved amount.

Approved facility is a hospital or clinic that provides medical and other services, such as skilled nursing care or physical therapy, and has been approved as a provider by BCBSM. Approved facilities **must** meet all applicable local and state licensing and certification requirements. Approved facilities must also be accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

Approved hospital is a hospital that meets all applicable local and state licensure and certification requirements, is accredited as a hospital by state or national medical or hospital authorities or associations, and has been approved as a provider by BCBSM or an affiliate of BCBSM.

Autologous transplant is a procedure using the patient's own bone marrow or peripheral blood stem cells for transplantation back into the patient.

Blue Cross and Blue Shield Association is an association of independent Blue Cross and Blue Shield Plans that licenses individual Plans to offer health benefits under the Blue Cross Blue Shield name and

logo. The Association establishes uniform financial standards but does not guarantee an individual Plan's financial obligations.

Blue Cross Blue Shield of Michigan is a nonprofit, independent company. BCBSM is one of many individual Plans located throughout the U.S. committed to providing affordable health care. It is managed and controlled by a board of directors comprised of a majority of community-based public and subscriber members.

Benefit is coverage for health care services available in accordance with the terms of your health care coverage.

Clinical trial is a study conducted on a group of patients to determine the effect of a treatment. It generally includes the following phases:

- Phase I – A study conducted on a small number of patients to determine what the side effects and appropriate dose of treatment may be for a certain disease or condition
- Phase II – A study conducted on a large number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment
- Phase III – A study on a much larger group of patients to compare the results of a new treatment of a condition to a conventional or standard treatment

  Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

COBRA is continuation coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1986.

Contraceptive device is a device such as, but not limited to, a diaphragm, intrauterine device or contraceptive implant designed to prevent pregnancy.

Copayment is the designated portion of the approved amount you are

required to pay for covered services. This can be either a fixed dollar or percentage amount.

Coordination of benefits is a program that coordinates your health benefits when you have coverage under more than one group health plan.

Covered services are services, treatments or supplies identified as payable under the State Health Plan *PPO*. Covered services must be medically necessary to be payable, unless otherwise specified.

Custodial care is care mainly for helping a person with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, eating or taking medicine. This care may be given with or without:

- Routine nursing care
- Training in personal hygiene and other forms of self-care
- Supervision by a physician

Deductible is the specified amount that you pay during each benefit period for services before your plan begins to pay.

Designated cancer center is a site approved by the National Cancer Institute as a comprehensive cancer center, clinical cancer center, consortium cancer center or an affiliate of one of these centers.

Designated facility is a facility that BCBSM determines to be qualified to perform a specific organ transplant.

Durable medical equipment is equipment that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to a person in the absence of illness or injury. A physician must prescribe this equipment.

Emergency first aid is the initial exam and treatment of conditions resulting from accidental injury.

End Stage Renal Disease is permanent and irreversible kidney failure that can no longer be controlled by medication or fluid and dietary restriction and, as such, requires a regular course of dialysis or a kidney transplant to maintain the patient's life.

Experimental or investigative is a service, procedure, treatment, device or supply that has not been scientifically demonstrated to be safe and effective for treatment of the patient's condition. BCBSM makes this determination based on a review of established criteria such as:

- Opinions of local and national medical societies, organizations, committees or governmental bodies
- Accepted national standards of practice in the medical profession
- Scientific data such as controlled studies in peer review journals or literature
- Opinions of the Blue Cross and Blue Shield Association or other local or national bodies

Freestanding facility is a facility separate from a hospital that provides outpatient services, such as skilled nursing care or physical therapy.

Freestanding outpatient physical therapy facility is an independently owned and operated facility, separate from a hospital, that provides outpatient physical therapy services and occupational or functional occupational therapy or speech and language pathology services.

High-dose chemotherapy is a procedure that involves giving a patient cell destroying drugs in doses higher than approved by the FDA for therapy.

Hospital is a facility that provides inpatient diagnostic and therapeutic services for injured or acutely ill patients 24 hours every day. The facility also provides a professional staff of licensed physicians and nurses to supervise the care of patients.

Independent physical therapist is a licensed physical therapist that is not employed by a hospital, physician or freestanding outpatient physical therapy facility and who maintains an office separate from a hospital or freestanding outpatient physical therapy facility with the equipment necessary to adequately provide physician-prescribed physical therapy.

In-network refers to services received by providers who are part of the Community Blue/Blue Preferred PPO Network.

Medical emergency is a condition that occurs suddenly, producing severe signs and symptoms, such as acute pain. A person would reasonably expect that this condition could result in serious bodily harm without prompt medical treatment.

Medical necessity, unless otherwise specified, is a service that must be medically necessary in order to be covered by the State Health Plan PPO.

Medical necessity for payment of hospital services requires that all of the following conditions be met:

- The covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease.
- The service, treatment or supply is appropriate for the symptoms and is consistent with the diagnosis.
  - — “Appropriate” means the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.
  - — For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient’s condition because safe and adequate care cannot be received as an outpatient or in a less intense medical setting.
- The services are not mainly for the convenience of the member or health care provider.

- The treatment is not generally regarded as experimental or investigational by BCBSM.
- The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment programs.

In some cases, you may be required to pay for services *even when they are medically necessary*. These limited situations are:

- When you don't inform the hospital that you are a BCBSM member either at the time of admission or within 30 days after you've been discharged
- When you fail to provide the hospital with information that identifies your coverage

Medical necessity for payment of physician services is determined by physicians acting for their respective provider types or medical specialty and is based on criteria and guidelines developed by physicians and professional providers. It requires that:

- The covered service is generally accepted as necessary and appropriate for the patient's condition, considering the symptoms. The covered service is consistent with the diagnosis.
- The covered service is essential or relevant to the evaluation or treatment of the disease, injury, condition or illness. It is not mainly for the convenience of the member or physician.
- The covered service is reasonably expected to improve the patient's condition or level of functioning. In the case of diagnostic testing, the results are used in the diagnosis and management of the patient's care.

The BCBSM determination of medical necessity for payment purposes is based on standards of practice established by physicians.

Member is any person eligible for health care services under the State

Health Plan *PPO*. This includes the subscriber and any eligible dependents listed in BCBSM membership records.

Network providers are providers who have met PPO standards and signed agreements to participate in the Community Blue/Blue Preferred network and to accept our approved amount as payment in full for covered services.

Nonparticipating providers are providers that have **not** signed participation agreements with Blue Cross Blue Shield of Michigan agreeing to accept the BCBSM payment as payment in full. However, nonparticipating professional (nonfacility) providers may agree to accept the BCBSM-approved amount as payment in full on a per claim basis.

Occupational therapy is treatment consisting of specifically designed therapeutic tasks or activities that:

- Improve or restore a patient's functional level when illness or injury has affected muscles or joints.
- Help the patient apply the restored or improved function to daily living.

Out-of-network costs are increased copayment and deductible amounts members may be responsible for if they go out-of-network without a referral. These costs could also include charges from a nonparticipating provider that are above the approved BCBSM amount.

Out-of-network refers to services *not* rendered by a PPO network provider.

Participating providers are providers who have signed agreements with BCBSM to accept the BCBSM-approved amount for covered services as payment in full.

Patient is the subscriber or eligible dependent (member) who is awaiting or receiving medical care and treatment.

Per claim is a provider's acceptance of the BCBSM-approved amount as payment in full for a specific claim or procedure.

Peripheral blood stem cell transplant is a procedure where blood stem cells are obtained by pheresis and infused into the patient's circulation.

Physical therapy is treatment that is intended to restore or improve the patient's use of specific muscles or joints, usually through exercise and therapy. The treatment is designed to improve muscle strength, joint motion, coordination and general mobility.

Physical therapy is **not** covered when services are principally for the general good and welfare of the patient (for example, developmental therapy or activities to provide general motivation) and when there is no improvement expected in the patient's condition.

Physician is a medical doctor (MD), doctor of osteopathy (DO), doctor of podiatric medicine (DPM), doctor of dental surgery (DDS) or doctor of medical dentistry (DMD).

Professional provider is a medical doctor (MD), doctor of osteopathy (DO), doctor of podiatric medicine (DPM), doctor of dental surgery (DDS), doctor of medical Dentistry (DMD) or a fully licensed psychologist.

Provider is a person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care.

Routine services are procedures or tests that are ordered for a patient without direct relationship to the diagnosis or treatment of a specific disease or injury.

Skilled nursing facility is a facility that provides convalescent and short- or long-term illness care with continuous nursing and other health care services by or under the supervision of a physician and a registered nurse. The facility may be operated independently or as part of an accredited

acute care hospital. It must meet all applicable local and state licensing and certification requirements.

Specialty hospital is a hospital, such as a children's hospital, a chronic disease hospital or a psychiatric hospital, that provides care for a specific disease or population.

Speech therapy is active treatment of speech, language or voice impairment due to illness, injury or as a result of surgery.

Stem cells are primitive blood cells originating in the marrow but also found in small quantities in the blood. These cells develop into mature blood elements including red cells, white cells and platelets.

Subscriber is the person who signed and submitted the application for State Health Plan *PPO* coverage.

We, Us, Our are used when referring to Blue Cross Blue Shield of Michigan.

You and Your are used when referring to any person covered under the State Health Plan PPO.